TEMPORARY ORTHOTIST & PROSTHETIST APPLICATION

ATTACH CHECK HERE

GEORGIA MEDICAL BOARD (GMB) USE ONLY

APPLICATION NUMBER		**FILE NUMBER**	
RECEIVED		**COMPLETED**	
TEMP LICENSE #		**DATE ISSUED**	
LICENSE NUMBER		**DATE ISSUED**	

ALL FEES ARE NONREFUNDABLE*

F E E S A R E S U B J E C T T O C H A N G E

Application Category: Please check one or more of the boxes below:

I would like to apply for a <u>temporary</u> license, based on the 7-year requirement. As a:

_____ Orthotist

_____ Prosthetist

_____ Orthotist/Prosthetist

NOTE: Temporary licenses <u>cannot</u> be renewed.

Please be aware that falsification or misrepresentation of any item or response on this application or any attachment hereto is sufficient basis for denying or revoking a license.

BASIC INFORMATION

PLEASE <u>PRINT</u> CLEARLY OR TYPE IN BLACK INK.

1. US Social Security Number: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

This information is authorized to be obtained and disclosed to state and federal agencies by O.C.G.A. § 19-11-1 and O.C.G.A. § 20-3-295, 42 U.S.C.A. § 651 and 20 U.S.C.A. § 1001. This information also may be disclosed to the Healthcare Integrity and Protection Data Bank (HIPDB) or other state medical boards or regulatory agencies for license tracking purposes.

2. LAST NAME	FIRST NAME	MIDDLE NAME	DEGREE

MAIDEN NAME	SEX M F	DATE OF BIRTH (MM/DD/YY)	

3. Mailing address – This address will be used to mail application status information.			
STREET NUMBER	STREET NAME		APARTMENT #
CITY	STATE	ZIP CODE	COUNTY
( )	( )		@
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER (OPTIONAL)		E-MAIL ADDRESS (**optional)**

4. Practice street address – This address will appear on the internet.			
STREET NUMBER	STREET NAME		SUITE #
CITY	STATE	ZIP CODE	COUNTY
( )	( )		
(AREA CODE) PHONE NUMBER	(AREA CODE) FAX NUMBER		

CERTIFICATION INFORMATION

5. Have you passed a national certification examination? ☐ **YES** ☐ **NO**

If yes, which examination:

_____Certification by the American Board for Certification in Orthotics and Prosthetics, Incorporated (ABC).

_____Certification by the Board of Orthotist/Prosthetist Certification (BOC).

☐ **Other** Please list:_____

DATE OF CERTIFICATION:_____

If no, indicate the date you are scheduled to sit and the name of examination:

Date Scheduled:_____ Examination Type:_____

APPLICANT QUESTIONNAIRE –

INSTRUCTIONS: If you answer, "YES" to questions 1-12, you are required to furnish complete details, including date, place, reason and disposition of the matter. Failure to furnish complete documentation may result in a delay in the processing of your application. I understand that my questionnaire may be selected for verification of the information provided. I recognize that providing false information or incomplete information may result in disciplinary actions against my license pursuant to O.C.G.A. §§ 43-1-19 and may result in criminal penalties, up to and including reporting to the Health Integrity and Protection Databank (HIPDB).	**YES**	**NO**
1. Have you ever been treated or hospitalized for mental illness, drug or alcohol abuse during the last seven years? (Provide the Board with all treatment history documentation to include diagnosis, treatment regimen, medical regimen, hospitalization, and on-going treatment/medication.)	❑	❑
2. Have you ever been arrested and/or convicted of a violation of any Federal (including military), State or Local statute?	❑	❑
3. Have you ever been denied the privilege of taking an examination given by any licensing Board or agency?	❑	❑
4. Has any licensing Board or agency ever denied you a certificate or a license?	❑	❑
5. Has any licensing Board or agency ever taken disciplinary action against you?	❑	❑
6. Has any licensing Board or agency ever refused you renewal of a certificate or a license?	❑	❑
7. Have you ever been denied membership in or in any way sanctioned by any Orthotics and/or Prosthetics association, society, or specialty society?	❑	❑
8. Have you ever voluntarily surrendered a license?	❑	❑
9. To your knowledge, are you the subject of an investigation by any licensing Board or agency as of the date of this application?	❑	❑
10. Do you have any applications for licensure pending before any other licensing Board or agency?	❑	❑
11. Have you ever been convicted of Medicaid or Medicare fraud, or had any restrictions as a Medicaid or Medicare provider?	❑	❑
12. Are you in default on a state or federally funded and/or guaranteed school loan?	❑	❑

AFFIDAVIT OF APPLICANT

TOP OF PHOTO (HEAD)

PHOTO AREA
PASTE A 2 ¼" X 3"
PHOTO HERE.

PHOTO MUST BE OF
YOUR HEAD
AND SHOULDER AREAS ONLY

BOTTOM OF PHOTO (SHOLDERS)

Notice: All items in this application are mandatory; none are voluntary. Failure to provide any of the requested information will delay the processing of your application. The information provided will be used to determine your qualifications for licensure per Georgia Law that authorizes collection of this information. The information on your application may be transferred to other medical licensing authorities the Federation of State Medical Boards or other governmental or law enforcement agencies.

I acknowledge and state that I have read the Application for Orthotist and Prosthetist Licensure Information and Applicant instructions that accompanied this application and I have answered all questions in compliance with these instructions. I acknowledge that it is my responsibility to read and become familiar with the Orthotics and Prosthetics Practice Act, and the Board Rules.

I further state that by filing this application for license to practice orthotics and prosthetics in the State of Georgia; I hereby authorize and consent to have an investigation made as to my moral character, professional reputation and fitness to practice. I agree to give any further information, which may be required in reference to my past record. I understand that I will not receive a copy of the report or know its content and I further understand that the contents of the investigative report will be privileged unless determined otherwise by the Board or Court Order.

I request and authorize any treatment program to release alcohol and drug abuse patient records to the Composite State Board of Medical Examiners for the purpose of evaluating my fitness to practice. The consent of this paragraph is subject to revocation pursuant to federal regulations and terminates upon the date of termination of licensure in Georgia.

I authorize and request every person, hospital, clinic, community, governmental agency (local, state, federal or International), court, association, institution, or other organization having control of my documents, records and other information pertaining to me, to furnish to the Georgia Composite State Board of Medical Examiners any such information, including documents, records regarding charges or complaints filed against me, formal or informal, pending or closed, or any other pertinent data and to permit the Georgia Composite State Board of Medical Examiners or any of its agents or representatives to inspect and make copies of such documents, records, and other information, in connection with this application, subsequent licensure or practice there under.

I authorize and request the Georgia Composite State Board of Medical Examiners to obtain any criminal history information concerning me from any authorized law enforcement agency, including but not limited to the Georgia Crime Information Center (GCIC) and the National Crime Information Center (NCIC).

I hereby release, discharge, and exonerate the Georgia Composite State Board of Medical Examiners, its agents or representatives, and any person so furnishing information, from any and all liability of every nature and kind arising out of the furnishing or inspection of such documents, records or other information or the investigation made by the Georgia Composite State Board of Medical Examiners.

This is to certify that the forgoing information is true and correct to the best of my knowledge. I understand that false swearing may constitute a felony offense under O.C.G.A. 16-10-71. I understand that working and falsely presenting myself to the public as licensed to practice as an orthotist and/or prosthetist is a violation of the Orthotics and Prosthetics Act and is a misdemeanor.

SIGNATURE OF APPLICANT	DATE	CITY	COUNTY	STATE

PRINTED NAME OF APPLICANT	Being duly sworn, says that he/she is the person who executed the above application for a license to practice orthotics and prosthetics in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.	NOTARY SEAL MUST BE IMPRINTED HERE

Sworn and subscribed to me this _____day of _____, _____

_____(Notary Public)

My Commission Expires

_____

FORM A – APPLICANT WORK HISTORY-
TEMOPRARY ORTHOTIST AND PROSTHETIST LICENSURE

APPLICANTS: Please complete your work history only as it relates to the practice of orthotics and/or prosthetics. For non-O & P related employment, please list the employer, dates employed, and job title. DO NOT list your job duties.

1. LAST NAME	FIRST NAME	MIDDLE NAME	MAIDEN NAME	DEGREE (MD OR DO)

	SEX M F	SOCIAL SECURITY NUMBER __ __ __ - __ __ - __ __ __ __	DATE OF BIRTH (MM/DD/YY) __ __ / __ __/ __ __ __ __ CHECK HERE IF YOU HAVE NEVER BEEN EMPLOYED ☐

STREET NUMBER	STREET NAME	APARTMENT #

CITY	STATE	ZIP CODE	COUNTY

2. **RECORD WORK HISTORY CHRONOLOGICALLY –** Complete Work History beginning with present employment. You must account for all breaks in work history, including, volunteer work and periods of unemployment.	E-MAIL ADDRESS

A. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	

B. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	

C. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	

D. NAME OF BUSINESS OR INSTITUTION:	**JOB TITLE**	
ADDRESS: STREET NUMBER STREET NAME	CITY STATE	ZIP CODE
SUPERVISOR'S NAME:		**DESCRIPTION OF DUTIES PERFORMED**
DATE OF EMPLOYEMENT/ATTENDANCE: FROM:_____/_____/_____ MONTH DAY YEAR TO: _____/_____/_____ MONTH DAY YEAR	% HOURS WORKED PER WEEK: _____ Clinical (DIRECT PATIENT CARE) _____ Technical (FABRICATION) TYPE OF EMPLOYMENT: ____FULL-TIME ____PART-TIME	

Applicant Signature: _____ Date:_____

If self-employed, check here:_____

FORM B
REFERENCE FORM – TEMPORARY ORTHOTIST AND PROTHETIST

To Applicant: The GEORGIA COMPOSITE STATE BOARD OF MEDICAL EXAMINERS requires completion of five **(5)** reference forms. Formal letters of reference are not accepted in lieu of the Reference Form since questions on the form are required by the Board. Have the reference sources complete the form and send it directly to **you. Do not open the envelope**; send it with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted.**

Please mail your form with your application packet to:

Georgia Composite State Boards of Medical Examiners
A T T E N T I O N : O R T H O T I S T A N D P R O S T H E T I S T L I C E N S U R E
2 Peachtree Street, NW - 36th Floor
Atlanta, GA 30303

In addition, the reference forms must come from the following individuals:
a. **2 references from current or former patients for whom you have provided services**.
b. **2 references from referral sources (i.e., physicians, physical therapists, case managers, etc.)**
c. **1** from current employer. If self-employed, please check here. _____ (if checked, only 4-references will be required.
d. The Board **does not accept faxed copies of the reference form**.

Applicant, be sure to indicate your name and address below for identification purposes.

NAME OF APPLICANT: _____

ADDRESS: _____

CITY, STATE AND ZIP CODE: _____

To Reference Source: Please complete this form, sign, and return to the **applicant** in a **sealed envelope** at the above stated address. Your response is confidential, pursuant to Georgia law. All applicants are required to sign a general release, which relieves anyone of any liability for information furnished in good faith. Please print or type all information. Please make sure the applicant's name is indicated on the form. **Sign your name across the back of the envelope.** The processing time for licensure directly depends on timely receipt of critical forms such as this.

ATTENTION: *The person who signs this form **MAY NOT** be related to the applicant by blood, marriage, or adoption, unless the person is your current employer.*

THIS POINT FORWARD IS TO BE COMPLETED BY THE REFERENCE SOURCE:

Please **print legibly:**

From: _____
First Middle Initial Last Degree

_____
Address City State Zip

_____
Area code Phone Number

_____
Area code FAX Number

PLEASE CONFIRM THAT THE FOLLOWING RESPONSES ARE CORRECT BEFORE SUBMITTING THIS FORM. INAPPROPRIATE ANSWERS WILL RESULT IN A DELAY IN PROCESSING THE APPLICATION.

Standard Questions

		Yes	No
1.	Have you ever received reports of poor clinical practice by this individual, or have you discussed concerns you had about this individual?	❑	❑
2.	Have you ever received reports of poor relationships between this individual and other members of the clinical staff?	❑	❑
3.	Are you aware of any derogatory information about this individual with respect to his/her ability to practice?	❑	❑
4.	Does this individual have, or has this individual had in the past, any mental or physical illnesses or personal problems that interfere with his/her practice?	❑	❑
5.	Has this individual ever abused alcohol or drugs or shown signs of chemical dependency?	❑	❑
6.	Are you aware of any lawsuits having to do with his/her practice that this individual has either lost or settled out of court?	❑	❑
7.	Are you aware of any restrictions, limitations or other actions of any nature taken against this individual by a health related entity?	❑	❑

Personal Information

1. How long have you known this practitioner? _____

2. Please explain your relationship to this practitioner.

_____

_____

3. In what capacity has this person worked with you?

_____

4. Describe your experience with this person.

_____

_____

5. Would you refer someone to this practitioner for treatment? ____YES ____NO

6. Do you recommend this individual for unrestricted licensure in Georgia? ____YES ____NO

_____
SIGNATURE

_____
Phone Fax

FORM C
VERIFICATION OF CLINICAL EXPERIENCE

INSTRUCTIONS: Complete the top portion of this form forward to each Program Director from the organization or agency in which you completed your directed experience relating to orthotics and/or prosthetics. If you require additional forms, you may photocopy this form. Your Program Director/Registrar will mail the form back to you. **Do not open the envelope**; send it with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted.**

NAME OF APPLICANT

US SOCIAL SECURITY NUMBER

			-			-					

DATE OF BIRTH

_____
MM/DD/YY

TO BE COMPLETED BY APPLICANT'S EMPLOYER OR YOURSELF (IF SELF-EMPLOYED):

EMPLOYER'S NAME	EMPLOYER ADDRESS	EMPLOYER'S CITY, STATE ZIP CODE	EMPLOYER'S PHONE NUMBER
W O R K E X P E R I E N C E :			
Dates of the applicant's work experience: _____ to _____ (from:Month/Day/Year) (To:Month/Day/Year)			

Complete description of job responsibilities as applied to license categories.

Supervisor's Name: _____

LICENSE NUMBER: (If applicable) _____

ABC and/or BOC CERTIFICATION NUMBER: (If applicable) _____

ATTENTION PROGRAM DIRECTOR OR REGISTRARS: Only the Program Director or Registrar may sign this form. If that signature authority is being delegated to another person, evidence of that delegation must be attached to this form (may be a photocopy). Such delegation must be on official letterhead and must be dated within the last 12 months.

NOTARY SEAL

_____
FULL NAME OF EMPLOYER(PLEASE TYPE OR PRINT)

_____
SIGNATURE OF EMPLOYER

I DECLARE UNDER PENALTY OF PERJURY, THAT I AM/WAS THE EMPLOYER FOR THE STUDENT NAMED ABOVE, THAT I HAVE CAREFULLY READ THIS FORM, AND THAT THE STATEMENTS MADE HEREIN ARE STRICTLY TRUE IN EVERY ASPECT.

FORM D
SUPERVISION VERIFICATION FORM

INSTRUCTIONS: Please print or type.

APPLICANT: Complete Part I – Applicant Information. This form should be sent to each O & P facility where you are/were employed. Verification of **7-years of full-time work history in a Georgia O & P facility** is required. **Have your present/former employer to sign his/her name across the back of the envelope. Do not open the envelope**; send it with your application packet. **Altered envelopes which contain official, original, certified official documents will not be accepted**

SUPERVISOR

Complete Part II and return to the Applicant in a **sealed envelope with your name across the back.**

PART I – APPLICANT INFORMATION			
NAME OF APPLICANT:			
First	**Middle**	**Last**	**Maiden**
SOCIAL SECURITY NUMBER:_____ _____ _____ - _____ _____ - _____ _____ _____ _____			

PART II – SUPERVISOR			
I HEREBY CERTIFY THAT I SUPERVISED THE ABOVE-NAMED INDIVIDUAL IN THE PRACTICE OF ORTHOTICS AND/OR PROSTHETICS AS FOLLOWS:			
Total Hours:	Hours Per week:	From:___/____/_____ Month/day/year	To: _____/_____/_____ Month/day/year
DESCRIPTION OF DUTIES SUPERVISED:			

I attest that I served as this Applicant's Supervisor, that this description is a true and accurate representation of my supervision of this Applicant, and I:

_____ Recommend for licensure
_____ Do Not Recommend for licensure

_____ _____
Date Signature of Supervisor

Address:_____
Street City State Zip Code

_____
Work Phone Fax Number

License Type:_____ License #:_____

Date Issued: _____ Expiration Date:_____

Being duly sworn, says that he/she is the person who executed the above application for a license to practice orthotics and prosthetics in the State of Georgia; and that all the statements herein contained are true in every respect and that the attached photo is a true photo of the applicant.	NOTARY SEAL MUST BE IMPRINTED HERE
Sworn and subscribed to me this _____day of _____, _____ _____(Notary Public)	My Commission Expires _____